Outpatient Authorization Request
Psychotherapy

To request authorization fax or mail to:
Optum Public Sector San Diego
PO Box 601340
San Diego, CA 92160-1340
Fax: (866) 220-4495 Phone: (800) 798-2254, option 3 then 4

*** Indicates a required field**

***SUBMIT DEMOGRAPHIC FORM WITH INITIAL REQUESTS**

Please check: ☐ Initial Request ☐ Continuing Request (Client seen by you within the last 6 months)

Client Information

*Client Name:	Gender: ☐ M ☐ F ☐ O	Age:	*DOB:	Client Ethnicity:

*Living Situation: ☐ Homeless ☐ Alone ☐ ILF ☐ B&C ☐ SNF ☐ Other, with whom?	*Medi-Cal #:

San Diego Regional Center Client: ☐ Yes ☐ No	Current Employment /School Status: ☐ Employed ☐ Student ☐ Homemaker ☐ Retired ☐ Unemployed ☐ Seeking Work ☐ Not in Labor Force ☐ Unknown ☐ Other

Justice System Involvement: ☐ N/A ☐ Yes If Yes, explain:

*Current Referral by Child and Family Well-Being (CFWB) Department: ☐ Yes ☐ No *If Yes, PSW name and number:	If History of CWS/CFWB, when and why?

Diagnosis and Other Clinical Considerations

*Primary DSM/ICD Diagnosis with Specifier:	*ICD Code:

Other Diagnoses (Mental & Physical Health):

Presenting Mental Health Problems and Symptoms

*Current Symptoms (List the frequency and duration) that result in impairment:

*Problem List: ☐ Reviewed/updated Date:
☐ No changes

Significant Impairment

***Distress, Disability, or Dysfunction in:**	**Yes**	**No**
Social/Relational	☐	☐
Occupational/Academic	☐	☐
Other Important Activities	☐	☐
Reasonable Probability of Signification Deterioration in an Important Area of Life Functioning	☐	☐
Reasonable Probability of Not Progressing Developmentally as Appropriate (If Under 21)	☐	☐

***Explain Significant Impairment:**

***History of Trauma and/or Abuse:** ☐ Yes ☐ No
*If Yes, explain:

***Substance Use:** ☐ No ☐ History ☐ Current *Drug(s) of choice:

*If current substance use, describe impact on functioning:

*Current Risk Assessment:	Suicidal: ☐ No ☐ Ideation ☐ Plan ☐ Intent ☐ History of harming self
	Homicidal: ☐ No ☐ Ideation ☐ Plan ☐ Intent ☐ History of harming others

Medications (Psychiatric, Medical & OTC)

Name of Medication:	Medication Dosage:	Name of Medication:	Medication Dosage:

☐ No Medications

Interventions

List Interventions (CBT, DBT, etc.):

☐ Group Therapy, Number of participants: Group Topic:

Provider Requested Authorization Units

<u>Important:</u> You must be a current contracted provider through Optum, Public Sector San Diego to be able to obtain authorization for services and payment.

Interpreter needed for these sessions: ☐ No ☐ Yes, Language:

If Initial Request, First Date of Assessment:

Treatment	***Begin Date of Sessions**	***Number of Sessions**	***Frequency Number of Sessions per Week/Month/Year**	**Optum Clinician Signature:** (For Optum Care Advocate Signature – Internal Use Only)
Psychotherapy (max 1 per day, max 12 total)				
Group Psychotherapy (max 12, specify length of session)				
Other:				
Team Conference (99366 or 99368) (max 1 unit per day)				
Targeted Case Management (T1017, 1 unit = 15 minutes)				
Targeted Case Management will focus on: ☐ Medical, Explain: ☐ Social, Explain: ☐ Educational, Explain: ☐ Other Services, Explain:				

Provider Information

*Name/Licensure:	
*Phone:	Fax:
*Provider Signature:	*Date:
If Group Practice, Name of Group:	

☐ **Check here to waive verbal notification of authorization determination for initial requests. Written notification will be sent for all requests.**